ForwardHealth
Wisconsin serving you

Update
October 2010

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Affected Programs: BadgerCare Plus, Medicaid
To: Adult Mental Health Day Treatment Providers, Advanced Practice Nurse Prescribers, Ambulatory Surgery Centers, Anesthesiologist Assistants, Audiologists, Case Management Providers, Certified Registered Nurse Anesthetists, Chiropractors, Community Support Programs, Comprehensive Community Service Providers, Crisis Intervention Providers, Dentists, End-Stage Renal Disease Service Providers, Family Planning Clinics, Federally Qualified Health Centers, HealthCheck Providers, HealthCheck "Other Services" Providers, Home Health Agencies, Hospital Providers, Intensive In-Home Mental Health and Substance Abuse Treatment Services for Children Providers, Master's Level Psychotherapists, Narcotic Treatment Services, Nurses in Independent Practice, Nurse Midwives, Nurse Practitioners, Nursing Homes, Occupational Therapists, Optometrists, Outpatient Mental Health Clinics, Outpatient Substance Abuse Clinics, Personal Care Agencies, Physical Therapists, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Portable X-Ray Providers, Prenatal Care Coordination Providers, Psychologists, Rehabilitation Agencies, Rural Health Clinics, Speech and Hearing Clinics, Speech-Language Pathologists, Substance Abuse Counselors, Substance Abuse Day Treatment Providers, Therapy Groups, HMOs and Other Managed Care Programs

New Prior Authorization Requirements for Advanced Imaging Services

Effective for dates of service on and after December 6, 2010, ForwardHealth will require prior authorization (PA) for most advanced imaging services, including CT, MR, and PET imaging. MedSolutions, a private radiology benefits manager, will administer PA for these services on behalf of ForwardHealth. Providers may begin submitting PA requests to MedSolutions on November 29, 2010. This *ForwardHealth Update* introduces MedSolutions and provides information about the PA process and requirements.

Overview of the New Prior Authorization Requirements

In response to 2009-2011 biennial budget targets, the Department of Health Services (DHS), along with representative industry stakeholders, undertook the Medicaid and BadgerCare Plus Rate Reform Project. As a result of the Rate Reform Project, ForwardHealth will begin requiring prior authorization (PA) for most advanced imaging services in an effort to do the following:

- Reduce redundancy of tests and prevent administration of unnecessary tests.
- Ensure the medical necessity of tests.
- Minimize member exposure to radiation.
- Apply national clinical guidelines for imaging services.

Effective for dates of service (DOS) on and after December 6, 2010, most advanced imaging services, including CT, MR, and PET imaging, will require PA when performed in either outpatient hospital settings or in non-hospital settings (e.g., radiology clinics). MedSolutions, a private radiology benefits manager, is authorized to administer PA for advanced imaging services on behalf of ForwardHealth. Providers will work directly with MedSolutions and should submit to MedSolutions all information necessary to make a PA determination. MedSolutions uses approved national clinical guidelines for imaging services when making PA determinations.

The provider who *orders* the advanced imaging service (e.g., the member's primary care physician, the member's

specialist) is required to work with MedSolutions to complete and submit the PA request for the service. Providers may begin submitting PA requests to MedSolutions on November 29, 2010, for DOS on and after December 6, 2010.

The provider or facility that *renders* the service should do the following prior to rendering the service:

- Verify the member's enrollment.
- Verify with MedSolutions (or with the ordering provider) that a PA has been approved for the member.

Prior authorization requirements apply to advanced imaging services for fee-for-service members enrolled in the following ForwardHealth programs:

- Medicaid.
- BadgerCare Plus Standard Plan.
- BadgerCare Plus Benchmark Plan.
- BadgerCare Plus Core Plan.
- BadgerCare Plus Basic Plan.
- Express Enrollment for Children.
- Express Enrollment for Pregnant Women.

Providers are not required to obtain PA separately for different ForwardHealth programs. If a member's enrollment status changes, PA granted for advanced imaging services under one plan will still be valid for the other plan.

Prior authorization is also required for members enrolled in state-contracted managed care organizations (MCOs) who receive physician and radiology services on a fee-for-service basis (e.g., Children Come First).

Providers are encouraged to obtain PA for advanced imaging services for members who are also enrolled in Medicare (dual eligibles). Prior authorization is not required on Medicare crossover claims, but if Medicare denies the claim or does not cover the services and the provider submits the claim for the services to ForwardHealth, all PA requirements apply.

Providers are encouraged to obtain PA for advanced imaging services for members who have other primary commercial health insurance. If commercial insurance denies or does not fully reimburse the claim and the provider submits the claim for the services to ForwardHealth, all PA requirements apply.

Refer to Attachment 1 of this *ForwardHealth Update* for a complete list of procedure codes that require PA. Services that are ancillary to an advanced imaging service (e.g., contrast agents or sedation) are not subject to PA requirements.

Providers are reminded that an approved PA does not guarantee reimbursement for the service.

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of the following program requirements is not met:

- The service authorized on the approved PA request is the service provided.
- The service is provided within the grant and expiration dates on the approved PA request.
- The member is eligible for the service on the date the service is provided.
- The provider is certified by Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider meets other program requirements.

Situations When Prior Authorization Is Not Required

In the following situations, PA is not required for advanced imaging services:

- The service is provided during a member's inpatient hospital stay.
- The service is provided when a member is in observation status at a hospital.
- The service is provided as part of an emergency room visit.
- The service is provided as an emergency service.

Emergency services are defined in DHS 101.03(52), Wis. Admin. Code, as "those services which are necessary to prevent the death or serious impairment of the health of the individual." Reimbursement is not guaranteed for services that normally require PA that are provided in emergency situations. As with all covered services, emergency services must meet all program requirements, including medical necessity, to be reimbursed by Wisconsin Medicaid. For example, reimbursement is contingent on, but not limited to, eligibility of the member, the circumstances of the emergency, and the medical necessity of the services provided.

If an integrated health plan or provider network implements a decision support system or other tool to manage utilization of advanced imaging services using comparable guidelines and monitors the success of the tool, the health plan or provider network may request to be exempted from requesting PA from MedSolutions. A future *Update* will give further details on the exemption request process.

MedSolutions Portal

Providers are encouraged to set up an account with MedSolutions online via the MedSolutions Portal at *www.medsolutionsonline.com/*. A MedSolutions Portal account allows ordering providers and providers who render services to perform the following business functions:

- Submit PA requests.
- Verify that an approved PA is on file for a member.
- View MedSolutions guidelines for making PA determinations.

Providers who have an existing account with MedSolutions may use that account to submit PA requests for ForwardHealth members beginning on November 29, 2010, for DOS on and after December 6, 2010.

For technical assistance with the MedSolutions Portal, providers may contact MedSolutions Portal Support at (800) 575-4594.

Requesting Prior Authorization for Advanced Imaging Services

The provider who orders the advanced imaging service should obtain PA for the service from MedSolutions because he or she likely has the most immediate access to the clinical information necessary to complete the PA request. ForwardHealth allows any provider who can order advanced imaging services within their scope of practice to complete and submit a PA request for advanced imaging services.

MedSolutions utilizes evidence-based clinical guidelines derived from national medical associations' recommendations to determine the medical necessity and appropriateness of the requested service(s). The guidelines are published on the MedSolutions Portal. MedSolutions will make a PA determination based on current ForwardHealth policy in conjunction with the MedSolutions guidelines. Providers are reminded that an approved PA does not guarantee reimbursement for the service.

Providers will be required to establish an account on the MedSolutions Portal to view the guidelines. Providers without Internet access can call MedSolutions at (800) 575-4517 for a copy of the guidelines on CD.

The provider or facility who renders the advanced imaging service and submits a claim for the service should verify with MedSolutions or with the ordering provider that an approved PA is on file for the member prior to rendering the service. Providers can verify PA through the MedSolutions Portal or by contacting MedSolutions at (888) 693-3211. If no PA is on file for the member, the provider rendering the services may request the PA prior to rendering the service if the provider can provide MedSolutions with the required clinical data. Providers should note that PA information for advanced imaging services will not display on the ForwardHealth Portal. Providers should always refer to MedSolutions to verify PA for advanced imaging services.

Any Medicaid-certified provider or facility that is currently able to perform advanced imaging services for members

based on current ForwardHealth policy can continue to render these services.

Submitting Prior Authorization Requests

Providers may submit PA requests using any of the following methods:

- MedSolutions Portal at *www.medsolutionsonline.com/* at any time. Providers are required to establish an account prior to submitting PA requests using the MedSolutions Portal. The MedSolutions Portal offers the most convenient method of submitting PA and allows providers to easily submit multiple PA requests. Providers are frequently able to obtain instant PA approval when using the MedSolutions Portal.
- Telephone at (888) 693-3211, Monday through Friday (excluding holidays) from 7:00 a.m. to 8:00 p.m. Central Time. MedSolutions is frequently able to make a PA determination during the telephone call.
- Fax at (888) 693-3210 at any time. Providers are required to use MedSolutions forms to submit PA requests via fax. Faxes received of any other forms will be returned to the provider unprocessed. MedSolutions forms are available through the MedSolutions Portal or by calling MedSolutions at (888) 693-3211.

MedSolutions is open Monday through Friday, 7:00 a.m. to 8:00 p.m. Central Time. MedSolutions will process PA requests received after hours on the next business day.

Information Required When Requesting Prior Authorization

Providers should have the following member and clinical information on hand when submitting a PA request to MedSolutions on the MedSolutions Portal, on the telephone, or via fax:

- Member's full name, date of birth, and address.
- Member's ForwardHealth member identification number.
- Member's working or differential diagnosis.
- Prior tests, lab work, and/or imaging performed related to the member's diagnosis.
- Type and duration of treatment performed to date for the diagnosis.
- Requested imaging service (e.g., "MRI of the brain") or requested procedure code if known. Providers should note that PA requests for advanced imaging services do not require modifiers even if the procedure code is billed with a modifier.
- A Medicaid-certified rendering facility. Providers should note that members may choose a different Medicaid-certified rendering facility than the one submitted to MedSolutions with the PA request. Amendments to the PA request are not required for a change in the rendering facility.

Having complete member and clinical information ready will expedite the PA determination process.

Prior Authorization Requests with Insufficient Clinical Data

If the provider submits a PA request with insufficient clinical data, MedSolutions will take the following actions:

- Suspend the PA request without adjudication.
- Contact the provider via fax up to three times over a period of five business days to request the additional information.

If the provider does not respond within 30 calendar days, MedSolutions will adjudicate the request based on all available information.

Prior Authorization Requests for Medically Urgent Situations

MedSolutions defines a PA request for a medically urgent situation as any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could have the following impact:

- Seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment.
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member

to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Requesting Prior Authorization Before Rendering the Service

For medically urgent situations, providers are encouraged to obtain PA prior to rendering the service when possible. Providers are required to call MedSolutions at (888) 693-3211 to obtain PA for urgent situations in cases where the service has not yet been rendered. MedSolutions will make a PA decision within 72 hours of receipt of all necessary information when the PA request is for an urgent situation. Providers should indicate clearly that the PA is for a medically urgent situation.

Note: MedSolutions does not accept PA requests via MedSolutions Portal or fax for medically urgent situations in cases where the service has not yet been rendered.

Requesting Prior Authorization After Rendering the Service

Although providers are encouraged to obtain PA for medically urgent situations prior to rendering the service when possible, MedSolutions will allow backdating for PA requests for advanced imaging services for medically urgent situations. Backdating for an urgent situation is allowed up to and including 14 calendar days after the service has been rendered.

A request for backdating may be approved if all of the following conditions are met:

- The provider specifically requests backdating in the PA request.
- The request includes clinical justification for beginning the service before PA was granted.
- The request is received by MedSolutions within 14 calendar days of the DOS.
- The request is submitted via telephone call at (888) 693-3211, via MedSolutions Portal, or via fax. If the provider submits a backdated PA request via fax, he or she is required to clearly indicate the DOS on the PA form.

Prior authorization may be denied if the PA request is received more than 14 calendar days after the DOS, does not meet the criteria for medical necessity, or does not meet the criteria for medically urgent situations. If the PA request is denied in this case, the provider cannot require payment from the member.

Communicating Prior Authorization Decisions

MedSolutions notifies the provider who submitted the PA request by fax whether a PA request is approved, approved with modifications, or denied. Providers should note that all PA communication is sent via fax from MedSolutions. Providers will not receive PA communications for PA requests for advanced imaging services in the mail unless MedSolutions is unable to send a fax (e.g., fax number is disconnected).

The provider who submitted the PA request receives a PA confirmation fax (in place of the ForwardHealth PA decision notice letter) when a PA request is approved. The PA confirmation fax includes information about the procedure codes that are approved for the member and the grant (effective) and expiration dates for the PA. Refer to Attachment 2 for a sample PA confirmation fax.

The provider who submitted the PA request receives a PA decision notice letter via fax when a PA request is denied. Prior authorization decision notice letters will be sent via fax. Refer to Attachment 3 for a sample PA decision notice letter.

The provider who submitted the PA request receives a PA decision notice letter when a PA request is approved with modifications. The PA decision notice letter includes information on both the approved and denied procedures.

Ordering providers are strongly encouraged to contact the provider who is rendering the service with information about the PA determination. The provider who renders the service

is strongly encouraged to verify which services and procedure codes are authorized for the member by using the MedSolutions Portal or by contacting the ordering provider prior to rendering services.

The provider who renders the service will not automatically receive separate notification from MedSolutions regarding PA approvals, modifications, or denials, except in cases where the provider who renders the service submitted the original PA request.

Prior Authorization Numbers

MedSolutions assigns a PA number to each PA request. The PA number consists of 10 digits, containing valuable information about the PA (e.g., the date the PA request was received by MedSolutions). Refer to Attachment 4 for information about interpreting PA numbers.

Prior Authorization Grant and Expiration Dates

Grant Date

The grant date (also known as the start or effective date) of an approved PA request is the first date for which the approved services are prior authorized and may be reimbursed. The grant date for PA requests for advanced imaging services is determined by the date that MedSolutions enters the PA request into their system. The grant date is usually the date that the provider submitted the PA request unless the PA request is received after normal business hours. The PA confirmation fax will indicate the grant or effective date of the PA.

Expiration Date

The expiration date (also known as the end date) of an approved PA request is the date through which the approved services are prior authorized. Prior authorization requests approved by MedSolutions are valid for 60 calendar days from the grant date. MedSolutions will not grant requests to extend the authorization period. To extend a PA authorization period, providers are required to submit a new PA request.

Prior Authorization Adjudication Process

MedSolutions will make a decision regarding a provider's PA request within 20 business days of the receipt of all the necessary information; however, MedSolutions is frequently able to make a PA determination immediately. If MedSolutions is unable to immediately approve a PA request, the PA request will be elevated to a nurse consultant for additional review. If the nurse consultant is unable to approve the PA request, the PA request will be elevated to a physician consultant. Only a physician consultant can deny a PA request based on his or her determination that the request does not meet clinical guidelines.

Approved Prior Authorization Requests

Prior authorization requests are approved for a period of 60 calendar days from the grant date. The provider who submitted the PA request receives a copy of a PA confirmation fax (in place of the ForwardHealth PA decision notice letter) when a PA request for a service is approved. Ordering providers are encouraged to share the information on the PA confirmation fax with the provider who renders the service. Providers may render the approved services beginning on the grant date.

The PA confirmation fax identifies the specific procedure codes that are approved. The provider who renders the service may substitute and perform a service defined by a different procedure code without contacting MedSolutions *only* when the substituted procedure code is considered a "downcode," as in the following situations:

- The provider renders a service without contrast when the approved service included contrast or included scans both with and without contrast.
- The provider renders a service with contrast when the approved service included scans both with and without contrast.

For example, if the PA confirmation fax authorizes procedure code 70470 (Computed tomography, head or brain; without contrast material, followed by contrast material[s] and further sections), the provider rendering the service may substitute and render procedure code 70450

(Computed tomography, head or brain; without contrast material) or 70460 (Computed tomography, head or brain; with contrast material[s]). This would be considered "downcoding."

Providers should refer to Attachment 1 for a list of allowable downcodes for each advanced imaging service that requires PA.

If other changes in procedure codes are necessary, such as an "upcode" or change in imaging modality, the provider who renders the service is required to contact MedSolutions to amend the PA request. Providers should be aware that PA amendments require approval from MedSolutions. Providers are strongly encouraged to obtain approval for a PA amendment prior to rendering services when possible.

Providers are encouraged to review approved PA requests before rendering the service to confirm the procedure code(s) authorized and confirm the assigned grant and expiration dates.

Prior Authorization Requests Approved with Modifications

Modification is a change in the services originally requested on a PA request. Modifications include a partial approval (part of the service is approved and part of the service is denied) or the authorization of a procedure code(s) different than the one(s) originally requested. Prior to modifying the PA request to authorize a different procedure code, MedSolutions contacts the provider who submitted the PA request by telephone. The provider must agree to the change in procedure code before the PA request can be approved. If the provider does not agree to the change, the PA request is denied.

When a PA request is modified, both the provider who submitted the PA request and the member are notified. The provider will be sent a PA decision notice letter via fax that includes information on both the approved and denied procedures and the reason the PA was modified. Ordering providers are encouraged to share the information on the PA decision notice letter with the provider who renders the service. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason the PA was modified and information on his or her right to a fair hearing. Only the *member, or authorized person acting on behalf of the member*, can appeal the modification.

Providers may call MedSolutions for clarification of why a PA request was modified.
The provider who requested the PA is required to discuss with the member the reason a PA request was modified and is encouraged to help the member understand the reason the PA request was modified.

Providers have the following options when a PA request is approved with modification:

- The provider who submitted the PA request may contact MedSolutions and request a reconsideration for the denied service(s). (This is only an option for PA requests for advanced imaging services and not for other services that require PA under ForwardHealth policy.)
- The provider who renders the service may provide the service as authorized.
- The provider who was to render the service may choose to not provide the service.
- The provider who renders the service may provide the service as originally requested as a noncovered service.

If the member does not appeal the decision to modify the PA request or appeals the decision but the decision to modify the PA request is upheld, the member may choose to receive the service(s) originally requested as a noncovered service and be responsible for payment.

Denied Prior Authorization Requests

When a PA request is denied, both the provider who submitted the PA request and the member are notified. The provider receives a PA decision notice letter via fax that includes the reason for PA denial. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was denied and information about his or

her right to a fair hearing. Only the *member, or authorized person acting on behalf of the member*, can appeal the denial.

Providers may call MedSolutions for clarification of why a PA request was denied.

The provider who requested the PA is required to discuss a denied PA request with the member and is encouraged to help the member understand the reason the PA request was denied.

Providers have the following options when a PA request is denied:

- The provider who submitted the PA request may contact MedSolutions and request a reconsideration for the denied service(s). (This is only an option for PA requests for advanced imaging services and not for other services that require PA under ForwardHealth policy.)
- The ordering provider or the provider who is to render the service may submit a *new* PA request.
- The provider who was to render the service may choose to not provide the service.
- The provider who renders the service may provide the service as a noncovered service.

If the member does not appeal the decision to deny the PA request or appeals the decision but the decision to deny the PA request is upheld, the member may choose to receive the originally requested service(s) as a noncovered service and to be responsible for payment.

Reconsideration Requests

The provider who submitted the PA request may contact MedSolutions to request a reconsideration of a denied or modified PA request for advanced imaging services. Reconsideration is an informal review of the denied or modified services conducted by a MedSolutions physician consultant. Providers should note that reconsideration is not an appeal. Only a member may appeal a PA determination after a PA request has been denied or modified.

The reconsideration must be requested within 14 calendar days of the PA denial or modification. Reconsiderations requested beyond 14 calendar days will not be processed. To request a reconsideration of a denied or modified PA request, providers should follow these steps:

- Call MedSolutions at (888) 693-3211.
- MedSolutions schedules a telephone conversation (a "peer-to-peer review") with either the MedSolutions physician consultant on duty or the physician consultant who made the PA determination. The provider should specify if he or she wants to talk to the physician consultant who made the PA determination.
- During the peer-to-peer review, the MedSolutions physician consultant may either reverse the decision based on additional clinical information and approve the PA request or uphold the original decision to deny or modify the PA request.

When a PA request is approved after reconsideration, the provider who submitted the PA request receives a PA confirmation fax. Ordering providers are encouraged to share the information on the PA confirmation fax with the provider who will render the service. It is the responsibility of the provider who submitted the PA request to notify the member if a PA request is approved after reconsideration.

Amendments to Approved Prior Authorization Requests

The provider rendering the service is required to contact MedSolutions to amend an approved PA request if, based on his or her medical judgment, it is more appropriate to render a different or more involved service than the one originally approved. Providers are strongly encouraged to request a PA amendment prior to rendering services when possible.

Prior authorization amendments will be required in the following circumstances:

- The provider renders a service with contrast when the approved service did not include contrast (i.e., "upcodes"). For example, the provider renders a service indicated by procedure code 70460 (Computed tomography, head or brain; with contrast material[s])

when the PA confirmation fax authorized procedure code 70450 (Computed tomography, head or brain; without contrast material).

- The provider renders a service with scans both with and without contrast when the approved services did not include contrast or only included scans with contrast (i.e., "upcodes"). For example, the provider renders a service indicated by procedure code 70470 (Computed tomography, head or brain; without contrast material, followed by contrast material[s] and further sections) when the PA confirmation fax authorized procedure code 70450 (Computed tomography, head or brain; without contrast material) or 70460 (Computed tomography, head or brain; with contrast material[s]).
- The provider images a different body part than originally approved. For example, the PA confirmation fax authorized procedure code 72192 (Computed tomography, pelvis; without contrast material) but the provider renders a service indicated by procedure code 72131 (Computed tomography, lumbar spine; without contrast material).
- The provider uses a different imaging modality than originally approved. For example, the PA confirmation fax authorized procedure code 70450 (Computed tomography, head or brain; without contrast material) but the provider renders a service indicated by procedure code 70551 (Magnetic resonance [eg, proton] imaging, brain [including brain stem]; without contrast material).

The provider rendering the service is *not* required to contact MedSolutions to "downcode" an approved service.

Providers have up to 14 calendar days after the DOS to amend an approved PA request. Amendment requests are subject to additional medical review and may be denied if the PA amendment request is not deemed medically necessary. If the amendment request is denied in this case, the provider cannot request payment from the member since the member was not notified in advance that the service was noncovered.

MedSolutions will make a decision regarding a provider's amendment request within 20 business days from the receipt of all necessary information.

The provider who submitted the PA amendment request should request a copy of the PA notification and provide a valid fax number to MedSolutions After adjudicating the PA amendment request, MedSolutions will notify the provider by fax whether the PA amendment request was approved, approved with modifications, or denied.

Appealing Prior Authorization Decisions

If a PA request is denied or modified by MedSolutions, only a member, or authorized person acting on behalf of the member, may file an appeal with the Division of Hearings and Appeals (DHA). Decisions that may be appealed include denial or modification of a PA request.

The member is required to file an appeal within 45 days of the date of the Notice of Appeal Rights letter.

To file an appeal, members may complete and submit a Request for Fair Hearing form, DHA-28 (08/09).

Though providers cannot file an appeal, they are encouraged to remain in contact with the member during the appeal process. Providers may offer the member information necessary to file an appeal and help present his or her case during a fair hearing.

Fair Hearing Upholds ForwardHealth's Decision

If the hearing decision upholds the decision to deny or modify a PA request, the DHA notifies the member and ForwardHealth in writing. The member may choose to receive the denied service (or in the case of a modified PA request, the originally requested service) as a noncovered service, not receive the service at all, or appeal the decision. If the member chooses to receive noncovered services, the member is responsible for payment of the services.

Fair Hearing Overturns ForwardHealth's Decision

If the hearing decision overturns the decision to deny or modify the PA request, the DHA notifies ForwardHealth and the member. The letter includes instructions for the provider and for ForwardHealth.

If the DHA letter instructs the provider to submit a claim for the service, the provider should submit the following to ForwardHealth after the service(s) has been performed:

- A paper claim with "HEARING DECISION ATTACHED" written in red ink at the top of the claim.
- A copy of the hearing decision.
- A copy of the denied PA request.

Providers are required to submit claims with hearing decisions to the following address:

ForwardHealth
Specialized Research
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Claims with hearing decisions sent to any other address may not be processed appropriately.

If the DHA letter instructs the provider to submit a new PA request, the provider is required to submit the *new* PA request to MedSolutions via fax with a copy of the hearing decision. Providers should clearly indicate that the PA request is for a fair hearing decision and should indicate the requested authorization date. If the service has already been performed, the requested authorization date should be the DOS. If the service has not been performed, the requested authorization date should be the earliest date that the service may be performed. MedSolutions does not accept PA requests for overturned hearing decisions via telephone or MedSolutions Portal.

MedSolutions will then approve the PA request for the overturned hearing decision. When a PA request is approved after an appeal, the provider who submitted the PA request receives a PA confirmation fax. Ordering providers are encouraged to share the information on the PA confirmation fax with the provider who rendered or will render the service. The provider rendering the service may then submit a claim following the usual claims submission procedures after providing the service(s).

Submitting Claims for Advanced Imaging Services

Claims for advanced imaging services should be submitted to ForwardHealth using normal procedures and claim completion instructions. Providers should always wait two full business days from the date on which MedSolutions approved the PA request before submitting a claim for an advanced imaging service that requires PA. This will ensure that ForwardHealth has the PA on file when the claim is received.

Procedure codes for advanced imaging services that require PA and do not have a valid PA on file will deny on both professional and institutional claims. Providers who submit institutional claims are reminded that effective for dates of receipt on and after July 1, 2010, institutional claims require procedure codes with revenue codes. Institutional claims submitted for advanced imaging services without a procedure code will be denied. Refer to the March 2010 *Update* (2010-22), titled "ForwardHealth Now Requiring Outpatient Hospitals to Include HCPCS or CPT Codes with Most Revenue Codes on Claims," and the July 2010 *Update* (2010-59), titled "Additional Revenue Codes Exempt from Requirement to Include HCPCS or CPT Codes on Outpatient Hospital Claims," for more information.

Billing for Technical and Professional Components

Only one approved PA is required for both the technical and professional components of the service, even when billed by different providers. Providers should continue to submit claims for advanced imaging services with the appropriate modifier for the technical and professional component, when applicable.

Claims for Medicare Dual Eligibles

Crossover claims for members who are also enrolled in Medicare (dual eligibles) are not subject to PA requirements; however, if Medicare denies the service or does not cover the service and the provider bills the service on a straight Medicaid claim, the provider is required to have obtained PA in order for the procedure code to be reimbursable.

Submitting Claims for Advanced Imaging Services That Do Not Require Prior Authorization

In the following situations, PA is not required for advanced imaging services:

- The service is provided during a member's inpatient hospital stay.
- The service is provided when a member is in observation status at a hospital.
- The service is provided as part of an emergency room visit.
- The service is provided as an emergency service.

Service Provided During an Inpatient Stay

Advanced imaging services provided during a member's inpatient hospital stay are exempt from PA requirements.

Institutional claims for advanced imaging services provided during a member's inpatient hospital stay are automatically exempt from PA requirements. Providers submitting a professional claim for advanced imaging services provided during a member's inpatient hospital stay should indicate place of service (POS) code "21" ("Inpatient Hospital") on the claim.

Service Provided for Observation Status

Advanced imaging services provided when a member is in observation status at a hospital are exempt from PA requirements.

Providers using a paper institutional claim form should include modifier "UA" in Form Locator 44 (HCPCS/Rate/HIPPS Code) with the procedure code for the advanced imaging service. To indicate a modifier on an institutional claim, enter the appropriate five-digit procedure code in Form Locator 44, followed by the two-digit modifier. Providers submitting claims electronically using the 837 Health Care Claim: Institutional (837I) should refer to the appropriate companion document for instructions on including a modifier.

Providers using a professional claim form should indicate modifier "UA" with the advanced imaging procedure code.

Service Provided as Part of Emergency Room Visit

Advanced imaging services provided as part of an emergency room visit are exempt from the PA requirements.

Providers using an institutional claim form should include modifier "UA" in Form Locator 44 with the procedure code for the advanced imaging service. Providers submitting claims electronically using the 837I should refer to the appropriate companion document for instructions on including a modifier.

Providers using a professional claim form should indicate POS code "23" ("Emergency Room—Hospital") on the claim.

Service Provided as Emergency Service

Advanced imaging services provided as emergency services are exempt from the PA requirements.

Providers using an institutional claim form should include modifier "UA" in Form Locator 44 with the procedure code for the advanced imaging service. Providers submitting claims electronically using the 837I should refer to the appropriate companion document for instructions on including a modifier.

Providers using a professional claim form should submit a claim with an emergency indicator.

Training Sessions Available

In November and December 2010, MedSolutions and ForwardHealth will be conducting Web-based orientation

training sessions for providers on PA procedures for advanced imaging services. All attendees are required to register prior to attending any of the scheduled training sessions; however, there is not a fee for attending. Separate registration is required for each training.

The following topics will be covered in the training sessions:
- Prior authorization requirements for advanced imaging services.
- Using the MedSolutions Portal to submit PA requests.
- Types of services and procedure codes requiring PA.
- Members for whom PA is required.

Refer to Attachment 5 for specific training session dates and times. The same information will be covered at all of the sessions.

Training Registration

Providers are required to register online or by telephone prior to attending any of the scheduled training sessions. Providers with Internet access are strongly encouraged to use online registration.

Online Registration

Providers may register online using the following steps:
- Go to the MedSolutions Portal at *medsolutions.webex.com/*.
- Click on the "Training Center" tab at the top of the page.
- Click on the "Upcoming" tab and select the date and time of the training session the provider plans to attend. Training sessions for Wisconsin Medicaid are titled "Wisconsin Medicaid Provider Orientation Session."
- Click "Register."
- Enter all required registration information.

After registering for a training session, the provider will receive an e-mail containing the following information:
- The toll-free telephone number and passcode needed for the audio portion of the training session.
- A link to the Web-based portion of the training session.
- The password for the training session.

Providers should keep the registration e-mail because the telephone number, Web address, and password are needed to participate in the training session.

Telephone Registration

Providers who do not have Internet access can register by calling MedSolutions at (615) 468-4029 or by e-mailing MedSolutions at *andrew.cline@medsolutions.com*. The provider will be given the following information:
- The toll-free telephone number and passcode needed for the audio portion of the training session.
- A link to the Web-based portion of the training session.
- The password for the training session.

Providers should write down this information because the telephone number, Web address, and password are needed to participate in the training session.

Questions Regarding Registration

Providers who have questions about registration or are unable to attend a training session for which registration has been confirmed should call MedSolutions at (615) 468-4029.

Training Session PowerPoint

Providers who are unable to participate in any of the training sessions may request a copy of the presentation by e-mailing MedSolutions at *andrew.cline@medsolutions.com*. MedSolutions will e-mail a copy of the Microsoft® PowerPoint of the training session in Portable Document Format (PDF).

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to advanced imaging services members receive on a fee-for-service basis only. For policy regarding advanced imaging services covered by an MCO, contact the appropriate MCO. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT 1
Advanced Imaging Services Requiring Prior Authorization

The following tables list *Current Procedural Terminology* and Healthcare Common Procedure Coding System procedure codes for advanced imaging services that require prior authorization (PA) unless the service is rendered in one of the exempted situations. Providers should work with MedSolutions to obtain PA for advanced imaging services. This list is subject to change. Providers should refer to the Online Handbook for a current list.

Computed Tomographic Imaging Procedure Codes Requiring Prior Authorization		
Procedure Code	**Description**	**Allowable Procedure Codes for Downcoding***
70450	Computed tomography, head or brain; without contrast material	N/A
70460	with contrast material(s)	70450
70470	without contrast material, followed by contrast material(s) and further sections	70450, 70460
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	N/A
70481	with contrast material(s)	70480
70482	without contrast material, followed by contrast material(s) and further sections	70480, 70481
70486	Computed tomography, maxillofacial area; without contrast material	N/A
70487	with contrast material(s)	70486
70488	without contrast material, followed by contrast material(s) and further sections	70486, 70487
70490	Computed tomography, soft tissue neck; without contrast material	N/A
70491	with contrast material(s)	70490
70492	without contrast material followed by contrast material(s) and further sections	70490, 70491
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	N/A
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	N/A
71250	Computed tomography, thorax; without contrast material	N/A
71260	with contrast material(s)	71250
71270	without contrast material, followed by contrast material(s) and further sections	71250, 71260

Computed Tomographic Imaging Procedure Codes Requiring Prior Authorization (Continued)		
Procedure Code	**Description**	**Allowable Procedure Codes for Downcoding***
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	N/A
72125	Computed tomography, cervical spine; without contrast material	N/A
72126	with contrast material	72125
72127	without contrast material, followed by contrast material(s) and further sections	72125, 72126
72128	Computed tomography, thoracic spine; without contrast material	N/A
72129	with contrast material	72128
72130	without contrast material, followed by contrast material(s) and further sections	72128, 72129
72131	Computed tomography, lumbar spine; without contrast material	N/A
72132	with contrast material	72131
72133	without contrast material, followed by contrast material(s) and further sections	72131, 72132
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	N/A
72192	Computed tomography, pelvis; without contrast material	N/A
72193	with contrast material(s)	72192
72194	without contrast material, followed by contrast material(s) and further sections	72192, 72193
73200	Computed tomography, upper extremity; without contrast material	N/A
73201	with contrast material(s)	73200
73202	without contrast material, followed by contrast material(s) and further sections	73200, 73201
73206	Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	N/A
73700	Computed tomography, lower extremity; without contrast material	N/A
73701	with contrast material(s)	73700
73702	without contrast material, followed by contrast material(s) and further sections	73700, 73701
73706	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	N/A

Computed Tomographic Imaging Procedure Codes Requiring Prior Authorization (Continued)		
Procedure Code	**Description**	**Allowable Procedure Codes for Downcoding***
74150	Computed tomography, abdomen; without contrast material	N/A
74160	with contrast material(s)	74150
74170	without contrast material, followed by contrast material(s) and further sections	74150, 74160
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	N/A
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	N/A
74262	with contrast material(s) including non-contrast images, if performed	74261
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	N/A
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	N/A
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	N/A
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)	N/A
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post processing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	N/A
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing	N/A

Computed Tomographic Imaging Procedure Codes Requiring Prior Authorization (Continued)		
Procedure Code	**Description**	**Allowable Procedure Codes for Downcoding***
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation	N/A
76377	requiring image postprocessing on an independent workstation	N/A
76380	Computed tomography, limited or localized follow-up study	N/A
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)	N/A
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	N/A
77079	appendicular skeleton (peripheral) (eg, radius, wrist, heel)	N/A
S8092	Electron beam computed tomography (also known as ultrafast CT, cine CT)	N/A

* If an allowable procedure code for downcoding is substituted for the approved procedure code, providers do not need to contact MedSolutions to amend the PA request.

Magnetic Resonance Imaging Procedure Codes Requiring Prior Authorization		
Procedure Code	**Description**	**Allowable Procedure Codes for Downcoding***
70336	Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)	N/A
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)	N/A
70542	with contrast material(s)	70540
70543	without contrast material(s), followed by contrast material(s) and further sequences	70540, 70542
70544	Magnetic resonance angiography, head; without contrast material(s)	N/A
70545	with contrast material(s)	70544
70546	without contrast material(s), followed by contrast material(s) and further sequences	70544, 70545
70547	Magnetic resonance angiography, neck; without contrast material(s)	N/A
70548	with contrast material(s)	70547
70549	without contrast material(s), followed by contrast material(s) and further sequences	70547, 70548
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	N/A
70552	with contrast material(s)	70551
70553	without contrast material, followed by contrast material(s) and further sequences	70551, 70552

Magnetic Resonance Imaging Procedure Codes Requiring Prior Authorization (Continued)		
Procedure Code	**Description**	**Allowable Procedure Codes for Downcoding***
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	N/A
70555	requiring physician or psychologist administration of entire neurofunctional testing	N/A
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)	N/A
71551	with contrast material(s)	71550
71552	without contrast material(s), followed by contrast material(s) and further sequences	71550, 71551
71555	Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)	N/A
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	N/A
72142	with contrast material(s)	72141
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	N/A
72147	with contrast material(s)	72146
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	N/A
72149	with contrast material(s)	72148
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	72141, 72142
72157	thoracic	72146, 72147
72158	lumbar	72148, 72149
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)	N/A
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)	N/A
72196	with contrast material(s)	72195
72197	without contrast material(s), followed by contrast material(s) and further sequences	72195, 72196
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)	N/A

Magnetic Resonance Imaging Procedure Codes Requiring Prior Authorization (Continued)		
Procedure Code	**Description**	**Allowable Procedure Codes for Downcoding***
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)	N/A
73219	with contrast material(s)	73218
73220	without contrast material(s), followed by contrast material(s) and further sequences	73218, 73219
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	N/A
73222	with contrast material(s)	73221
73223	without contrast material(s), followed by contrast material(s) and further sequences	73221, 73222
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)	N/A
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)	N/A
73719	with contrast material(s)	73718
73720	without contrast material(s), followed by contrast material(s) and further sequences	73718, 73719
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material	N/A
73722	with contrast material(s)	73721
73723	without contrast material(s), followed by contrast material(s) and further sequences	73721, 73722
73725	Magnetic resonance angiography, lower extremity, with or without contrast material(s)	N/A
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)	N/A
74182	with contrast material(s)	74181
74183	without contrast material(s), followed by with contrast material(s) and further sequences	74181, 74182
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)	N/A
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	N/A
75559	with stress imaging	75557
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	75557

Magnetic Resonance Imaging Procedure Codes Requiring Prior Authorization (Continued)		
Procedure Code	**Description**	**Allowable Procedure Codes for Downcoding***
75563	with stress imaging	75557, 75559, 75561
75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)	N/A
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation	N/A
76377	requiring image postprocessing on an independent workstation	N/A
76390	Magnetic resonance spectroscopy	N/A
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	N/A
77058	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral	N/A
77059	bilateral	N/A
77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply	N/A
S8035	Magnetic source imaging	N/A
S8037	Magnetic resonance cholangiopancreatography (MRCP)	N/A

* If an allowable procedure code for downcoding is substituted for the approved procedure code, providers do not need to contact MedSolutions to amend the PA request.

Positron Emission Tomographic Imaging Procedure Codes Requiring Prior Authorization		
Procedure Code	**Description**	**Allowable Procedure Codes for Downcoding***
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation	N/A
78491	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress	N/A
78492	multiple studies at rest and/or stress	78491
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation	N/A
78609	perfusion evaluation	N/A
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	N/A
78812	skull base to mid-thigh	N/A
78813	whole body	N/A
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	N/A
78815	skull base to mid-thigh	N/A
78816	whole body	N/A

* If an allowable procedure code for downcoding is substituted for the approved procedure code, providers do not need to contact MedSolutions to amend the PA request.

ATTACHMENT 2
Sample Prior Authorization Confirmation Fax

(A sample "Prior Authorization Confirmation Fax" is located on the following page.)

MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

MedSolutions has been recognized for providing "An Outstanding Customer Service Experience" under the esteemed J.D. Power and Associates Certified Call Center Program. For J.D. Power and Associates Certified Call Center Program[SM] information, visit jdpower.com

730 Cool Springs Boulevard, Suite 800, Franklin, TN 37067
Fax:888-693-3210/ Phone: 888-693-3211

Prior Authorization Confirmation Fax

Case ID : 7777777	**Case Type :** Phone
Auth ID: A12121212	**Effective :** Mon, Oct 05, 09
Status : Approved	**Expires :** Thurs, Dec 03, 09

Patient Information

Name : DOE, JOHN	**DOB :** Dec 20, 1900
HP MemberID : 0000000001	**HealthPlan :**Sample Health Plan
Address : 123 ANY STREET ANYCITY, ST, 99999	

Performing Provider Information

Authorized Facility : ANYNAME RADIOLOGY	**HealthPlan Id :** 00000000XXXX
Address : 456 ANY STREET, ANYCITY, ST 99999	**Phone :** 800/555-1212
	Fax :

Referring Physician Information

Procedure Requested by: DOE, JANE	**HealthPlan Id :**
Address : 1234 ANY STREET ANYCITY, ST 99999	**Phone :** 800/555-1213
Specialty : GENERAL SURGERY	**Fax :**

Clinical Information

ICD9	Procedure
784.0	Headache; Other symptoms involving the head or neck.

CPT	Unit	Status	Procedure
70551	1	Approved	MRI Brain or Head; without contrast material

MedSolutions is an independent company selected to manage high-tech radiology services. The authorization is for medical necessity and does not guarantee claims payment, which is based on member benefits.

If you have questions please contact Customer Service at 1-888-693-3211.

Fax sent to 5555551212 on Mon, Oct 05, 09 2:33 PM

ATTACHMENT 3
Sample Prior Authorization Decision Notice Letter

(A sample "Prior Authorization Decision Notice Letter" is located on the following page.)

December 20, 2010

Dr. IMA DOCTOR
123 MAPLE STREET
ANYTOWN, WI 55555

PA Number: 9103540123
PA Status: DENIED
IM A MEMBER

Dear Dr. IMA DOCTOR:

Your request for prior authorization (PA) has been finalized based on criteria established by the Department of Health Services and as stated in DHS 106.03 (4), Wis. Admin. Code. Refer to the adjudication detail on the enclosed attachment for the service specific authorization.

An authorized PA does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to the approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus or Medicaid Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

A “Notice of Appeal Rights” letter has been sent to the member. Only the member, or authorized person acting on behalf of the member, may file an appeal with the Division Hearings and Appeals. Providers are encouraged to remain in contact with the member during the appeal process. Providers may offer the member information necessary to file an appeal and help present his or her case during a fair hearing.

If you have any questions regarding the decisions made on this PA, please contact MedSolutions at (888) 693-3211.

Sincerely,

Gregg Allen, MD
Chief Medical Officer
MedSolutions, Inc.

Member Name: IM A MEMBER
Member Identification Number: 123456789

Provider Name: Dr. IMA DOCTOR
Provider Address: 123 MAPLE STREET
ANYTOWN, WI 55555|
Provider Identification Number: 987654321

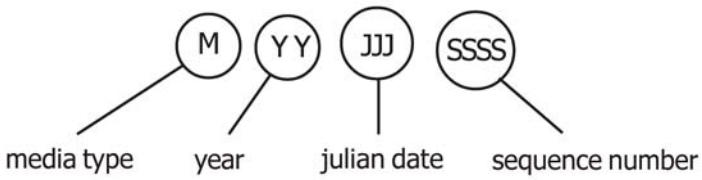
PA Number: 9103540123
PA Status: DENIED

78816 POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; WHOLE BODY

0178 - THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.

ATTACHMENT 4
Interpreting Prior Authorization Numbers

Each prior authorization (PA) request is assigned a unique PA number. This number identifies valuable information about the PA. The following diagram and table provide detailed information about interpreting the PA number.



Type of Number and Description	Applicable Numbers and Description
Media — One digit indicates media type.	Prior authorization requests received by MedSolutions for advanced imaging services are always identified with media type "9."
Year — Two digits indicate the year MedSolutions received the PA request.	For example, the year 2010 would appear as 10.
Julian date — Three digits indicate the day of the year, by Julian date, that MedSolutions received the PA request.	For example, February 3 would appear as 034.
Sequence number — Four digits indicate the sequence number.	The sequence number is used internally by MedSolutions.

ATTACHMENT 5
Web-Based Orientation Sessions for Prior Authorization for Advanced Imaging Services Training Schedule

Date	Time
November 16, 2010	9:00 a.m.
November 18, 2010	11:00 a.m.
November 23, 2010	11:00 a.m.
November 24, 2010	1:00 p.m.
November 30, 2010	12:00 p.m.
December 2, 2010	9:00 a.m.
December 7, 2010	4:00 p.m.
December 8, 2010	9:00 a.m.